MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1105 76

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Carroll

City or town: Westfield Twp

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or insl. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Wayfield Twp Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Rural Westminster

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Elmira Aldridge

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: Geo. W. Aldridge deceased.

6 (c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 5, 1860

8. AGE: Years: 87 Months: 1 Days: 13 If less than one day: ____ hrs. ____ min.

9. Birthplace: Carroll Co. Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: James Barnes

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Catherine Shipley

MOTHER 15. Birthplace: Maryland

16. Informant: Mrs. Anna M. O'Laughlin

Address: 3031 Windsor Ave Balto Md

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 12-21-47 (month) (day) (year)

Cemetery or ~~crematory~~: Bethel Church of God.

Location: Winfield, Carroll Co. Md

18. Funeral director: C. M. Coats

Address: Winfield Md.

19. 12/20 19 47 (Date rec'd by registrar) F. L. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 18th 1947, at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 — 1947, to Dec 18 1947, and that I last saw her alive on Dec 18 — 1947

	DURATION
Immediate cause of death: acute Cardiac Decompensation.	5 hrs
Due to Chronic myocarditis	2 yrs
Due to Chronic Interstitial nephritis	4 yrs
Due to Arteriosclerosis	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Alvan R. Fouty MD M. D. or other

Address: Westminster Md Date signed 12-19-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11051

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 610 Collett Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Bernice Anderson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Separated

6.(b) Name of husband or wife: Edward Anderson
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): September 22, 1913

8. AGE: Years	Months	Days	If less than one day
34	3		hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Edward Gibson
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Bertha Powell
15. Birthplace: Howard Co, Maryland

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-27-47 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Ana Arundel County
18. Funeral director: Geo. E. Kelson
Address: 1303 Pressman St.

19. Dec. 22 1947 (Date rec'd by registrar) Albert R. Swanbeck Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 22 1947 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 18 1947 to Dec. 22 1947 and that I last saw her alive on December 22 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Kuman M.D.
M.D. or other
Address: Henryton, Maryland Date signed: 12/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11052

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Yr., 6 Mons., 7 Days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or Institution? Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Faulkner
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOHN LEWIS BARBER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 28, 1927

8. AGE: Years	Months	Days	If less than one day
20	6	6	hrs. min.

9. Birthplace: Wicomico (Charles) Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Joseph Barber
13. Birthplace: Maryland

MOTHER
14. Maiden name: Marie Middleton
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 8, 1947 (month) (day) (year)
Cemetery ~~or crematory~~
Location: Newport, Charles Co., Maryland
18. Funeral director: Alexander S. Pope
Address: 315-15th st. S.E. Wash., 3, D. C.

19. Dec. 4, 1947 (Date rec'd by registrar) Albert R. Swanham Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4, 1947 at 8:P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27, 1946 to Dec. 4, 1947 and that I last saw h im alive on December 4, 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: June 3rd 1946
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

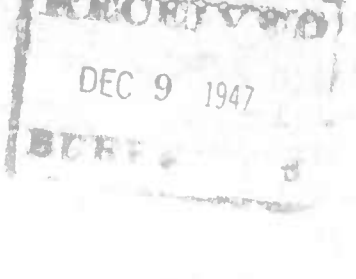
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work? ✓

23. SIGNATURE: Reuben W. Swan, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 12-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 81

1. PLACE OF DEATH:
County: Carroll Co
City or town: Near Middleburg Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yr.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: near Middleburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Edward Biddinger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: Mary M. Biddinger
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): 1971 - 5 - 29

8. AGE: Years	Months	Days	If less than one day
76 75	6	21	hrs. min.

9. Birthplace: Frederick Co Md
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER
12. Name: Ephrum Biddinger
13. Birthplace: Frederick Co Md

MOTHER
14. Maiden name: Sarah Pippeon
15. Birthplace: Frederick Co Md

16. Informant: Mary M. Biddinger
Address: Middleburg Md.

17. Burial, cremation, or removal. Which? Burial Date thereof 12-22-47 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Woodsboro Md.

18. Funeral director: Raymond T. Wright
Address: Union Bridge. Md

19. Dec 20, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 19 1947 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 14 - 1947 to Dec 19 1947 and that I last saw h... alive on Dec 19 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to Arterio Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

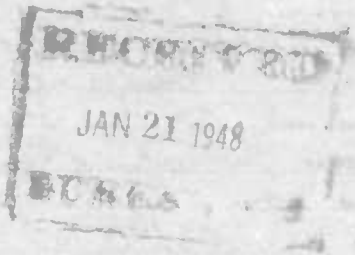
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. H Hegg M. D. or other
Address: Union Bridge Date signed 12-20-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 11053 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos. 17 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bush Chapel Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Madison Lee Bond

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Married

6.(b) Name of husband or wife: Emma Bond
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 27, 1913

8. AGE: Years	Months	Days	If less than one day
34	9	1	hrs. min.

9. Birthplace: Aberdeen, Maryland (Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business

FATHER
12. Name: George H. Bond
13. Birthplace: Aberdeen, Maryland

MOTHER
14. Maiden name: Mae Thomas
15. Birthplace: Aberdeen, Maryland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 2 1948 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Aberdeen, Md.
18. Funeral director: Harry Jennings Sons
Address: Aberdeen Md.

19. Dec. 28 19 47 (Date rec'd by registrar) Albert R. Smallwood Local Deputy Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH: December 28 19 47 at 8:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9, 19 47 to Dec. 28 19 47 and that I last saw h... im alive on December 28 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Offutt, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 12/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11054

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH
County Carroll
City or town New Windsor (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Rural
Hospital, Institution, or street address where death occurred: 6 months
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Penna. County Dauphin
City or town Dauphin (If outside city or town limits, write RURAL and give nearest town)
Street No. R. D. #1 (If rural, give LOCATION)
2.(a) If veteran, name war 1

3.(a) FULL NAME Emma May Boyd

3.(b) Social Security Number 207-07-7272

4. Sex female
5. Color or race white
6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife George Boyd
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 9- 1874

8. AGE: Years 73 Months 3 Days 10 If less than one day hrs. min.

9. Birthplace Carroll County, Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Peter Fritz
13. Birthplace maryland

MOTHER
14. Maiden name Margaret Bowers
15. Birthplace Maryland

16. Informant Oliver Fritz
Address New Windsor, Md R. D.

17. Burial (Burial, cremation, or removal) Which? Date thereof 12/21/47 (month) (day) (year)
Cemetery or crematory Pipe Creek Cemetery
Location Uniontown Road
18. Funeral director C. H. Stabler & Sons
Address Union Bridge & New Windsor, Md
19. Dec 20 1947 Emma Bucket (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1947 at 4:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1947, to Dec 19 1947
and that I last saw h.. alive on Dec 18 1947

Immediate cause of death	DURATION
Due to Intestinal obstruction	
Due to Carcinoma	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. I. Hegg M. D. or other
Address Union Bridge Md Date signed 12-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11055

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Manitteville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Manitteville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Henry Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Margaret Ann

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 27 1865

8. AGE: Years	Months	Days	If less than one day
81	11	15	..... hrs. ..... min.

9. Birthplace Sykesville (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name Charles G. Brown

13. Birthplace Maryland

MOTHER

14. Maiden name Lucinda

15. Birthplace Unknown

16. Informant Mrs. Albert F. Shipley

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 15 47 (month) (day) (year)

Cemetery or crematory Springfield

Location Sykesville Md.

18. Funeral director C. H. Meer

Address Sykesville Md.

19. Dec 13 1947 (Date rec'd by registrar) C. H. Meer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 19 47 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1, 1947 to Dec 12, 1947 and that I last saw him alive on Dec. 11, 1947

Immediate cause of death	DURATION
Cardio vascular Disease	
Due to	
Due to	
Other conditions Asthma	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other

Address Randalletown Md. Date signed 12/14/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11056

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. 27 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton (a) If veteran, name war

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 56 Hanover Street
(If rural, give LOCATION)

3. (a) FULL NAME: Viola Mae Brown

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Married

6.(b) Name of husband or wife: Oscar Brown

6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): February 14, 1914

8. AGE: Years	Months	Days	If less than one day
33	9	24	..... hrs. ..... min.

9. Birthplace: Seebert, W. Virginia
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: John Henderson
13. Birthplace: W. Virginia

MOTHER
14. Maiden name: Woodsey Tibbs
15. Birthplace: W. Virginia

16. Informant: Deceased
Address:

17. Burial, cremation, or removal. Which? Remove Date thereof: Dec. 10 1947 (month) (day) (year)

Cemetery or crematory: Mell Pond

Location: Marlinton W. Va

18. Funeral director: Sharp Funeral Home

Address: Aberdeen Md

19. Dec. 8 19 47 (Date rec'd by registrar) Albert R. Smallwood Registrar
Local Deputy

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: December 8 19 47 at 4:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11 19 47, to December 8 19 47 and that I last saw her alive on December 8 19 47

Immediate cause of death: Pulmonary Tuberculosis — DURATION: March 1947

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 12/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11057

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Millers, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Millers, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME JOHN J. BUSER

3.(b) Social Security Number 220-26-7414

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of ~~husband or~~ wife: Eliza Mafe

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 14. 1877

8. AGE: Years 69 | Months 11 | Days 19 | If less than one day: ..... hrs. ..... min.

9. Birthplace: York Co Pa (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: Isaac Buser

FATHER 13. Birthplace: York Co. Pa

MOTHER 14. Maiden name: Mary Ann Walter

MOTHER 15. Birthplace: York Co. Pa

16. Informant: Jesse W. Wentz

Address: Finksburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 6 1947 (month) (day) (year)

Cemetery or crematory: New Church

Location: Brodbeck Co Rd

18. Funeral director: H. Keefer & Son

Address: New Oak, Pa.

19. Dec. 3 1947 (Date rec'd by registrar) Mrs. W. P. S. Benner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 3 1947, at 1 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1947 to Dec. 3 1947 and that I last saw h.s.r.a. alive on Dec. 1 1947

Immediate cause of death	DURATION
Congestive heart failure	3 mo.
Due to: Arthio-Sclerotic Heart disease	2 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Maurice C. Carter M.D. (or other)

Address: Hampstead Md. Date signed: 12-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11058

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1820 Laurens Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Cecelia Carroll

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 29, 1902

8. AGE: Years	Months	Days	If less than one day
45	0	2	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Frank Carroll
13. Birthplace: St. Mary 's Co. Md.

MOTHER
14. Maiden name: Eliza Clinton
15. Birthplace: St. Mary's Co. Md.

16. Informant: Sister: Elsie Williams

Address: 1820 Laurens Street. Balto.Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/14/47 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: West Port

18. Funeral director: Thomas Kelson

Address: 1303 Pennsylvania Ave Balto

19. Dec 1 19 47 (Date rec'd by registrar) Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1 19 47 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 25 19 47 to Dec. 1 19 47 and that I last saw her alive on December 1 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben O'Rowan, M. D.
M. D. or other

Address: Henryton, Md. Date signed 12/1/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11059

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 Days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1214 Madison Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Viola Ramona Carvens

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 7, 1930

8. AGE: Years	Months	Days	If less than one day
17	7	23	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: James Carvens

13. Birthplace: Alabama

MOTHER 14. Maiden name: Mary Pearl

15. Birthplace: Maryland

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 2, 1948 (month) (day) (year)

Cemetery or crematory Mt. Auburn

Location

18. Funeral director: Mrs Robert Elliott & daughter

Address 1129 N. Caroline St

19. Dec. 30 1947 (Date rec'd by registrar) Albert R. Counihan Local Deputy Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH December 30 1947 at 8:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 1947 to Dec. 30 1947 and that I last saw her alive on December 30 1947

	DURATION
Immediate cause of death: Air embolism incident	
to pneumothorax	Dec. 26
Due to	1947
Due to	
Other conditions: Pulmonary Tuberculosis	July
	1947

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hyman, M.D.
M. D. or other

Address Henryton, Maryland Date signed 12/30/47

W

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Item 6!
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11060

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr 12 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 762 Dolphin Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Rachel Adele Cook

3.(b) Social Security Number:

4. Sex: female
5. Color or race: col
6.(a) Single, married, widowed, or divorced: Separated
6.(b) Name of husband or wife: ~~Joshua~~ George Cook
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): September 10, 1904
8. AGE: Years: 43 Months: 3 Days: 7 If less than one day: hrs. min.
9. Birthplace: Earl, Virginia (Town, county, and state)
10. Usual occupation: Office Machine Operator
11. Industry or business:

FATHER
12. Name: Asa Perry
13. Birthplace: Earl, Virginia

MOTHER
14. Maiden name: Clara Halloway
15. Birthplace: Earl, Virginia

16. Informant: Brother- Mr. Asa Perry
Address: 2510 Francis St, Balto. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 21, 1947 (month) (day) (year)
Cemetery or crematory: Family Lot
Location: Amelia Va
18. Funeral director: Wm. T. A. Gibson
Address: 1735 Druid Hill Ave.
19. Dec. 17, 1947 (Date rec'd by registrar) Albert R. Swanhart Local Deputy Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: December 17 19 47 at 9:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 5 19 46 to Dec. 17 19 47 and that I last saw h er alive on December 17 19 47

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Oct. 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Walker W. Kuman, M. D.
M. D. or other
Address: Henryton, Maryland Date signed: 12/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11061

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Reese - Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mo.

Hospital, institution, or street address where death occurred: Reese 7.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Reese - Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 7 - N. Pleasant Valley

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Robert East Apthorpe Dorr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 26 - 1879

8. AGE: Years: 68 | Months: 6 | Days: 4 | If less than one day: hrs. min.

9. Birthplace: New York City (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Robert E. A. Dorr

13. Birthplace: N. Y.

MOTHER — 14. Maiden name: Bertha Kinney

15. Birthplace: N. Y.

16. Informant: Robert D. Goodall

Address: Baltimore, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1/3/48 (month) (day) (year)

Cemetery or crematory: Church of Messiah Cem.

Location: Gwynwd., Penna.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 12/30 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 30 19 47 at 3a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Arteriosclerosis	
Due to:	
Other conditions: Bronchial Asthma	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: James F. Hood Deputy Med. Examiner

M. D. or other

Address: Westminster Md. Date signed 12-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

11743

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

Reg. Dist. No. 81

1. PLACE OF DEATH:

County: Carroll Co

City or town: Bark Mill Near Union Bridge Rt #4
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life Time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Near Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Nora Eckard

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
F	W	L

6.(b) Name of husband or wife: Harry Eckard

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): 30 Nov 1873

8. AGE:	Years	Months	Days	If less than one day
	74		22	hrs. min.

9. Birthplace: Carroll Co
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER
12. Name: David Winters
13. Birthplace: Carroll Co

MOTHER
14. Maiden name: Sarah Smith
15. Birthplace: Maryland

16. Informant: Harry Eckard
Address: Union Bridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-24-47 (month) (day) (year)

Cemetery or crematory: Church of God

Location: Unionville Md

18. Funeral director: Raymond K. Wright

Address: Union Bridge Md

19. Dec 22 1947 Luba L. Repp
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 22 1947, at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1947, to Dec 22 1947 and that I last saw h... alive on Dec 20 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J H Legg
M. D. or other

Address: Union Bridge Date signed 12-22-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

11063

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Poplar Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural --- Mt. Airy
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOHN DENTON FL EMING

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife: Mary E. Fleming
6.(c) If alive, give age: deceased years

7. Birth date of deceased (mo., day, yr.): June 6, 1883

8. AGE: Years 64 | Months 5 | Days 28 | If less than one day: hrs. min.

9. Birthplace: Howard Co. Maryland (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: State of Maryland

FATHER
12. Name: John J. Fleming
13. Birthplace: Maryland

MOTHER
14. Maiden name: Hannah Driver
15. Birthplace: Maryland

16. Informant: Mr. George D. Fleming
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 12-7-47 (month) (day) (year)
Cemetery ~~or crematory~~: Morgan Chapel
Location: Day, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Dec 6 1947 (Date rec'd by registrar) C. Harry Wenz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4, 1947, at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 3, 1947, to Dec 4, 1947 and that I last saw him alive on Dec 4 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 da
Due to: Arterio-Sclerosis	2 yrs
and Hypertension	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other
Address: Mt Airy, Md Date signed 12/5/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11062

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos. 2 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Malcolm (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Barnard Ford

3.(b) Social Security Number: 215-26-0073

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): November 3, 1924

8. AGE: Years	Months	Days	If less than one day
23	1	26	... hrs. ... min.

9. Birthplace: Malcolm, Maryland (Town, county, and state)

10. Usual occupation: Farm Laborer

11. Industry or business

FATHER 12. Name: James Ford

FATHER 13. Birthplace: Charles County, Maryland

MOTHER 14. Maiden name: Mary Bridge

MOTHER 15. Birthplace: Charles County, Maryland

16. Informant: Deceased

Address

17. burial (Burial, cremation, or removal. Which?) Date thereof Jan. 1, 1948 (month) (day) (year)

Cemetery or crematory St. Peters Church

Location Waldorf Md.

18. Funeral director Hunt & Ryan

Address Waldorf Md.

19. Dec. 29 1947 (Date rec'd by registrar) Albert A. Grandhaus Local Deputy Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: December 29 1947, at 3:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27 1947, to December 29 1947 and that I last saw h... im alive on December 29 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Feb. 1944

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Reuben H. Hyman, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 12/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11064

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 Hour. 15 minutes
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or Institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 270 N. Exeter Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Freeman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Separated

6.(b) Name of husband or wife Agnes Freeman
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 25, 1902

8. AGE: Years	Months	Days	If less than one day
45	2	6	hrs. min.

9. Birthplace Chattanooga, Tennesee
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name John R. Freeman
13. Birthplace Georgia

MOTHER
14. Maiden name Lillie Powell
15. Birthplace Georgia

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 5th 1948 (month) (day) (year)
Cemetery or crematory Mt. Calvary Cem.
CHATTANOOGA TENNESSEE
Location ~~Cedar~~ Polk Road

18. Funeral director Mrs Robert Elliott daughter
Address 1129 N. Carolina St.

19. Dec. 31 1947 (Date rec'd by registrar) Albert R. Sandbower Registrar
Local Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 19 47 at 8:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 31 19 47 to Dec. 31 19 47 and that I last saw h... im alive on December 31 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben M. Fenn, M. D.
M. D. or other
Address Henryton, Maryland Date signed 12/31/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11065

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, Institution, or street address where death occurred:
6 Winnit Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6 Winnit Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Worthington Jackson Fringer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Not known
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
Count 75			hrs. min.

8. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Worthington Fringer
13. Birthplace Md.
MOTHER 14. Maiden name Sarah Wolfe
15. Birthplace Md.
16. Informant Roy Fringer
Address 6 Winnit Ave. Westminster, Md.
17. Burial Date thereof Dec 5 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Lutheran Cemetery
Location Jamy Town, Md.
18. Funeral director H B Bankard & Son
Address Westminster, Md.
19. 12/4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1947, at 4.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 - 1947, to Dec 3 - 1947
and that I last saw him alive on Dec 2 - 1947

Immediate cause of death	DURATION
acute cardiac Decompensation	4 hrs.
Coronary Myocarditis	2 yrs.
Due to Chronic Interstitial nephritis	6 yrs.
Due to Arteriosclerosis	15 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Alias R Fauth MD M. D. or other
Address Westminster Md. Date signed 12-4-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 e

11666

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Cora R. Gaither

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James M. Gaither

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 21st, 1890

8. AGE: Years	Months	Days	If less than one day
57	2	10	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER — 12. Name: John T. Richardson

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Amelia Gilliss

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Ethel Shipley

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 2, 1948 (month) (day) (year)

Cemetery or crematory: Mt. View

Location: Howard Co. Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Jan 1 1948 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30th 1947, at 8 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 1 1947, to Dec 30 1947

and that I last saw her alive on Dec 20, 1947

Immediate cause of death	DURATION
Carcinoma of Colon	
Due to Carcinoma of Colon	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Dr. E. Martin M. D. or other

Address: Randallstown Date signed 12/30/47

11667

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 3 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 815 N. Mount Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Wrighter Garnett

3.(b) Social Security Number: 212-07-0959

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Married

6.(b) Name of husband or wife: Catherine Garnett

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 5, 1905

8. AGE: Years	Months	Days	If less than one day
42	8	8	hrs. min.

9. Birthplace: Middletown, Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Jennifer Garnett
13. Birthplace: Middletown, Virginia

MOTHER
14. Maiden name: Virginia Crump
15. Birthplace: Middletown, Virginia

16. Informant: Deceased
Address:

17. Shipped (Burial, cremation, or removal. Which?) Date thereof 12/15/47 (month) (day) (year)

Cemetery or crematory:

Location: Middletown, Cotyra

18. Funeral director: Kate L. Williams

Address: 322 N. Schroeder Street

19. Dec. 13 19 47 (Date rec'd by registrar) Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13 19 47 at 9:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10 19 47 to Dec. 13 19 47 and that I last saw h... im alive on December 13 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Hyman, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 12/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

11068

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Johnsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Johnsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural --- Sykesville

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN GOSNELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of ~~husband or~~ wife: Alice Gosnell

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): January 1, 1878

8. AGE:

Years	Months	Days	If less than one day
69	11	3	....hrs. ....min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Phillip Gosnell

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Narcissa Hall

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Ella M. Chase

Address: Sykesville, Md.

17. (Burial, ~~cremation, or removal. Which?~~) Burial Date thereof 12-8-47 (month) (day) (year)

Cemetery ~~or crematory~~: Johnsville

Location: Johnsville, Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. (Date rec'd by registrar) Dec 9 1947 C. Henry Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec, 4, 1947, at 1:25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19.. to Dec 4 1947

and that I last saw h.. ~~in~~ alive on Dec 4, 1947 19..

Immediate cause of death	DURATION
General cardio-vascular disease	
With arteriosclerosis & myocarditis	
Due to senile changes	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D.

M. D. or other

Address: Sykesville Date signed 12/5/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11069

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Rural, Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mo., 7 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 5 mo., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4501 Underwood Road
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: GRITZAN, Theodore

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary C. Hammel

6.(c) If alive, give age: 87 years

7. Birth date of deceased (mo., day, yr.): 7-24-58

8. AGE: Years	Months	Days	If less than one day
89	5	1	....hrs. ....min.

9. Birthplace: Baltimore City
(Town, county, and state)

10. Usual occupation: Merchant tailor

11. Industry or business:

FATHER
12. Name: ?
13. Birthplace: Germany

MOTHER
14. Maiden name: Caherine Schuman
15. Birthplace: Germany

16. Informant: Records of Springfield State Hospital
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 27, 47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18. Funeral director: John Ullrich
Address: Orleans Street

19. Dec 26 19 47 (Date rec'd by registrar) C Harry Moser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 19 47, at 8.35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4 19 47, to December 25 19 47 and that I last saw him alive on December 25 19 47

Immediate cause of death	DURATION
Chronic myocarditis	?
Due to:	
Due to:	
Other conditions: Arteriosclerosis	?
Senile Psychosis, Hernia	about 1 yr

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.:

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of:

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Martin Gross, M.D. Martin Gross, M.D.
M. D. or other

Address: Sykesville, Md. Date signed: 12-26-47

W

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 11070

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days.

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 12 Days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1032 East Fort Avenue, Baltimore
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME
ADAM CHARLES GRUNDER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife: Esther Alice Nash

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): 2/28/94

8. AGE: Years	Months	Days	If less than one day
53	9	11	..... hrs. ..... min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual occupation: Fireman

11. Industry or business: Baltimore City Fire Dept.

FATHER
12. Name: Charles Clementine Grunder
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 15 47 (month) (day) (year)

Cemetery or crematory: Holy Cross

Location: Balto. Md. F. Dill

18. Funeral director: Md Charles [illegible]

Address: Balto., Md.

19. Dec 11 1947 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11 1947, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/29/47 19.. to Dec. 11 1947 and that I last saw him alive on Dec. 11 1947

Immediate cause of death	DURATION
Bronchopneumonia	36 hrs.
Due to:	
Due to:	
Other conditions: Mental Illness, type undetermined (Probably functional)	6 weeks

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other

Address: S.S. Hosp. Sykesville, Md. Date signed: 12-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11121

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 yrs

Hospital, institution or street address where death occurred:

42 Liberty St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 42 Liberty

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edward Heim

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Clearie E. Henry

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Oct. 12 - 1882

8. AGE: Years	Months	Days	If less than one day
65	2	5	hrs. min.

9. Birthplace East Prospect, York Co., Pa. (Town, county, and state)

10. Usual occupation Welder

11. Industry or business

FATHER

12. Name Phillip Heim

13. Birthplace Pa.

MOTHER

14. Maiden name Eliza Amstein

15. Birthplace Pa.

16. Informant Mrs Clearie E. Henry Heim

Address 42 Liberty St. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 20. 1947 (month) (day) (year)

Cemetery or crematory Prospect Cemetery

Location Westminster, Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. 12/18/47 19 47 L L Wood Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17th 19 47 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 19 46 to Dec 17 19 47

and that I last saw h alive on Dec 14 19 47

Immediate cause of death Chronic Myocarditis & Arteriosclerosis

DURATION: Several yrs

Due to

Due to

Other conditions Cardiac Decompensation - 3 mos

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L L Wood M. D. or other

Address Baltimore Date signed 12/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

11744

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92a

CERTIFICATE OF DEATH

Reg. Diat. No. 81

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Rural-Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Minnie J. Hockensmith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Charles R. Hockensmith 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 5, 1869

8. AGE: Years	Months	Days	If less than one day
78	2	10	hrs. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual occupation House work

11. Industry or business Own home

FATHER 12. Name Armor Boyd

13. Birthplace Penna.

MOTHER 14. Maiden name M Amanda Overholtzer

15. Birthplace Penna.

16. Informant C. Edgar Hockensmith

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/17/47 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Taneytown, Maryland

18. Funeral director C.O.Fuss & Son

Address Taneytown, Md.

19. Dec 16 1947 (Date rec'd by registrar) Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1947 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 3 1947 to Dec. 15, 1947 and that I last saw her alive on Dec. 13 1947

Immediate cause of death	DURATION
Aortic valvular heart disease	5 yrs.
Due to Arteriosclerosis	10 yrs.
Due to	
Other conditions Chronic Myocarditis and Myocardial degeneration	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations None performed Date of op.

Autopsy results None done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M.D. M. D. or other

Address Taneytown, Md. Date signed 12/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11672

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Williamsport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 27 W. Frederick St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3.(a) FULL NAME

EARL FRANKLIN HOSE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Hazel Hose

6.(c) If alive, give age: unkn years

7. Birth date of deceased (mo., day, yr.): Feb 27, 1897

8. AGE: Years	Months	Days	If less than one day
50	9	24	..... hrs. ..... min.

9. Birthplace: Washington Co., Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: ---

FATHER
12. Name: David Hose
13. Birthplace: Washington Co., Md.

MOTHER
14. Maiden name: Elizabeth ----
15. Birthplace: Washington Co., Md.

16. Informant: Hospital Records

Address

17. buried (Burial, cremation, or removal. Which?) Date thereof Dec 24 47 (month) (day) (year)

Cemetery or crematory: St Pauls Rt 40

Location: Rt 40 near clearspring

18. Funeral director: Edith V. Leap

Address: Williamsport

19. Dec 24 1947 (Date rec'd by registrar) C. H. Wood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21 19 47 at 3:10A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 3, 1947 to Dec. 21, 1947 and that I last saw him alive on Dec. 21 1947

Immediate cause of death	DURATION
Syphilitic Meningo-encephalitis	unkn.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D.
M. D. or other

Address: S.S.Hosp, Sykesville, Md. Date signed 12/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1318 11073

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 81 John St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Clara Virginia Hull

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): September 9, 1865

8. AGE: Years	Months	Days	If less than one day
82	3	16	... hrs. ... min.

9. Birthplace: Carroll County, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Oliver A. Hull

13. Birthplace: Maryland

MOTHER

14. Maiden name: Rachael Bowers

15. Birthplace: Maryland

16. Informant: Mrs. Rachael Myerly

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12/29/47 (month) (day) (year)

Cemetery or crematory: Warfieldsburg Cemetery

Location: Warfieldsburg, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 12/29/47 (Date rec'd by registrar) 19... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 19 47 at 6½ p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 35 to 12-25 19 47

and that I last saw h... F.R. alive on 12-25-47 19...

Immediate cause of death: Myocarditis (chr)

Nephritis (chr)

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. C. Jennette, M.D. M. D. or other

Address: Westminster Md. Date signed: 12-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46m

Reg. Diat. No. 11074

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs 5 mo 6 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 5 yrs 5 mo 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City ?
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ?
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: HYMAN, Harry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: -----

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. or June 15, 1894 or 96?

8. AGE: Years	Months	Days	If less than one day
51 or 53 ?	?	?	....hrs. ....min.

8. Birthplace: Baltimore, Md
(Town, county, and state)

10. Usual occupation: Odd jobs

11. Industry or business: -----

FATHER
12. Name: Jacob Hyman
13. Birthplace: Russia

MOTHER
14. Maiden name: Sarah Balisok
15. Birthplace: Russia

16. Informant: Records of Sprinfield State Hospital
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-22-47 (month) (day) (year)

Cemetery or crematory: B'Nai Israel

Location: Northern Ave

18. Funeral director: Jack Lewis, Inc

Address: 220 Eutaw Place

19. Dec 21 1947 (Date rec'd by registrar) C. N. Meed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20 1947 at 4.37 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 2nd 1947 to December 20 1947 and that I last saw him alive on December 20 1947

Immediate cause of death	DURATION
Cancer of the digestive tract	?
Due to	
Due to	
Other conditions: Right inguinal hernia	about 40yrs
Psychosis with mental deficiency	7 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of:

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ----- Injured at work?

Martin Gross, M.D.

23. SIGNATURE: Martin Gross, M.D.
M. D. or other

Address: Sykesville, Md Date signed: 12-20-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

not BC 11075

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Mon., 7 Days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1610 Waldo Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LOWETHEL JONES

3.(b) Social Security Number: 216-20-5426

4. Sex: Female
5. Color or race: Col.
6.(a) Single, married, widowed, or divorced: Married (Sep.)
6.(b) Name of husband or wife: Dolphis Jones
6.(c) If alive, give age: 33 years
7. Birth date of deceased (mo., day, yr.): December 6, 1915
8. AGE: Years: 32 Months: 0 Days: 0 If less than one day ..... hrs. ..... min.
9. Birthplace: Whitakers, N. Carolina
(Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Charles Austin
13. Birthplace: New Haven, Conn.

MOTHER
14. Maiden name: Betty A. Arrington
15. Birthplace: Nash Co., N. Carolina

16. Informant: Deceased
Address

(Burial, cremation, or removal. Which?) Shipped. Date thereof Dec. 8 1947 (month) (day) (year)
Cemetery or crematory Whitakers, N. C.
Location
18. Funeral director Mrs Katie R. Williams
Address 322 - N. Schroeder St
19. Dec. 6 19 47 (Date rec'd by registrar) Albert R. Smallwood Registrar
Local, Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1947 at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27, 1947 to Dec. 6, 1947 and that I last saw her alive on December 6, 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	July 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Reuben Hoffman, M. D. M. D. or other
Address Henryton, Md. Date signed 12-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 11076

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 4 mos. 17 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1014 E. Monument St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Margaret Jones

3. (b) Social Security Number: 212-20-2455

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 31, 1924

8. AGE: Years	Months	Days	If less than one day
23	8	1	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Laundry Worker

11. Industry or business:

FATHER
12. Name: Larnell Jones
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Eachel Butler
15. Birthplace: Baltimore, Maryland

16. Informant: Deceased
Address:

17. Burial, cremation, or removal. Which?: Burial Date thereof: 12/5/47 (month) (day) (year)

Cemetery or crematory: Mt Calvery

Location: A A County, Md.

18. Funeral director: Mrs Robert Elliott & daughter

Address: 1129 N. Caroline St.

19. 12/1 19 47 (Date rec'd by registrar) Albert R. Smallhouse Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2 19 47, at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 46, to Dec. 2 19 47 and that I last saw her alive on December 2 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben M. Fuman, M. D.
M. D. or other

Address: Henryton, Md. Date signed: 12/2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

Reg. Dist. No. 11677 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural, Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural, Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Jones

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 27, 1947

8. AGE:

Years	Months	Days	If less than one day
0	0	2	..... hrs. ..... min.

9. Birthplace: Mt. Airy, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Kersey Alexandr Jones

13. Birthplace: Conowingo, Md.

MOTHER

14. Maiden name: Rosalee Knight

15. Birthplace: Columbia, N. C.

16. Informant: Kersey A. Jones

Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation~~, or removal Which?) Date thereof 12-30-47 (month) (day) (year)

Cemetery or ~~crematory~~: Family Burial Ground.

Location: near Mt. Airy. Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield. Md.

19. Dec 29 19 47 (Date rec'd by registrar) Thos. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29, 1947 at 5:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27 19 47 to December 29 19 47 and that I last saw her alive on December 29 19 47

Immediate cause of death	DURATION
Anoxia	2 day
Due to: Premature	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Hawley Grabill M. D. or other

Address: Mt Airy, Md Date signed 12/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11078

55e

BC

Reg. Diat. No. 74

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: CARROLL

City or town: SYKESVILLE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? " 2 months, 2 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 2 monts, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. (or location): Patient lived at City Hospital since 1926 until 8/47 - trans. to Spring Grove - Trans. to Springfield 10/17/47 ✓

2.(a) If veteran, name war:

3.(a) FULL NAME

FRANK KISS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
54 (?)			hrs. min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Record, Springfield State Hospital

Address: sykesville maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec 23 1947 (month) (day) (year)

Cemetery or crematory: Springfield state Hospital Cem-

Location: sykesville maryland.

18. Funeral director: C Harry Warr

Address: sykesville maryland

19. Dec 23 1947 (Date rec'd by registrar) C. Harry Warr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19 1947 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 17 1947 to December 19 1947 and that I last saw him alive on December 19, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9/26/47
Melanosarcomatosis	unknown
Due to:	
Due to:	
Other conditions: Schizophrenia, hebephrenic type (Include pregnancy within 3 months of death)	21 years

Major findings of operations:

Date of op.

Autopsy results: Diffuse, widespread melanosarcomatosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 12/19/47

11073

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 24

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Greenville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Greenville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Lyksville P.O.,

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Robert L. Knoll

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Bertie Harry

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 6, 1875

8. AGE:

Years	Months	Days	If less than one day
72	7	12	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation National Window Cleaning Co

11. Industry or business Retired

FATHER 12. Name Louis J. Knoll

13. Birthplace Md.

MOTHER 14. Maiden name Louisa J. Beaver

15. Birthplace Md.

16. Informant Mrs. Bertie Knoll

Address Lyksville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 21, 1947 (month) (day) (year)

Cemetery or crematory Oakland Methodist Cem.

Location Nr. Oakland Mills Pikesville, Md.

18. Funeral director C. Henry Wees

Address Lyksville, Md.

19. Dec 19 1947 (Date rec'd by registrar) C. H. Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1947 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-29 1947, to 12-18 1947

and that I last saw him alive on 12-15 1947

Immediate cause of death

	DURATION
arteriosclerotic C-V. Disease Comp	
arteriosclerotic gangrene	3 mo
of left foot	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE D. D. Caples M.D. M. D. or other

Address Reisterstown, Md Date signed 12-18-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11080

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster, Route 4

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 4

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Laura Amanda Logue

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
feamle	white	married

6.(b) Name of husband or wife: George R. Logue

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): January 12, 1875

8. AGE:

Years	Months	Days	If less than one day
72	10	27	...hrs. ...min.

9. Birthplace: Pocomoke City, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: not known

13. Birthplace: " "

MOTHER 14. Maiden name: " "

15. Birthplace: " "

16. Informant: Mrs. Radcliffe Helm

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12/12/47 (month) (day) (year)

Cemetery or crematory: Deer Park Cemetery

Location: Smallwood, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 12/10 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9 1947, at 1½ p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 - 1947 to Dec 9 - 1947

and that I last saw h.. alive on Dec 9 - 1947

Immediate cause of death	DURATION
Pneumonia (Lobar)	9 days
Nephritis (chr.)	5
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. C. Jennette M.D. M. D. or other

Address: Westminster Md Date signed: 12-9-47

11081

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

938

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year.
Hospital, institution, or street address where death occurred: New Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: new Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Vernon Masemore

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widower

6.(b) Name of husband or wife: Mamie Margaret Masemore
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 11, 1873

8. AGE: Years: 74 | Months: 9 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Parkton, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: George F. Masemore
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Elizabeth Bull
15. Birthplace: Maryland

16. Informant: Harry M. Masemore
Address: Westminster Md RD #4

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-29-47 (month) (day) (year)

Cemetery or crematory: Pine Grove
Location: Raynella Balto Co Md

18. Funeral director: Elbert C Tipton
Address: Hampstead Md

19. Dec. 27 1947 (Date rec'd by registrar) Mrs. W. P. S. Demuth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26 1947 at 1 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1946 to Dec 26 1947 and that I last saw h[illegible] alive on Dec 15 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: Arterio Sclerotic Cardio-Vascular	
Due to: Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op.: —
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work? —

23. SIGNATURE: Jos E. Bush MD
M. D. or other
Address: Hampstead Md Date signed 12-26-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 (2C) 11082

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1008 Cathedral Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: VIOLA BEATRICE McNALLY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Bernard Aloysius McNally

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): 11/7/88

8. AGE: Years	Months	Days	If less than one day
59	1	9	...hrs. ...min.

9. Birthplace: Charlottesville, Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Samuel B. Henshaw
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Kennedy
15. Birthplace: Virginia

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. (Burial, cremation, or removal, Which?) Burial Date thereof 12-19-47 (month) (day) (year)

Cemetery or crematory: Meadow Ridge Memorial Park

Location: Balto., Co., Md. Wash. Blvd

18. Funeral director: William Cook, Inc.

Address: 12-17 St Paul St. Balto. Md.

19. Dec. 16 19 47 (Date rec'd by registrar) C. Harry Ebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 19 47 at 1:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 3 19 47 to Dec. 16 19 47 and that I last saw h 34 alive on December 15 19 47

Immediate cause of death	DURATION
Hypertensive Cardio-vascular Disease	6 yrs.
Cerebral hemorrhage	1 hrs. ago
Due to Cerebral hemorrhage	2 hrs. ago
Cerebral hemorrhage	3 days ago
Due to Bronchopneumonia	3 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of Injury ... Injured at work?

23. SIGNATURE: Joseph H. Marshall M.D.
M. D. or other

Address: Sykesville, Maryland Date signed: 12/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

11083

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Rural Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Emmanuel Taneytown, Md. & Littlestown, Pa.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Middleburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Gloria Martin Metcalfe

3.(b) Social Security Number 216-22-2018

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Calvin Lee Metcalfe 6.(c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) March 21 - 1927

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
20	8	18		

8. Birthplace Union Bridge Md. (Town, county, and state)

10. Usual occupation Bookkeeper

11. Industry or business Farm Co-Operative

FATHER 12. Name Blanchard Martin

13. Birthplace Union Bridge, Md.

MOTHER 14. Maiden name Virginia B. Bankard

15. Birthplace New Windsor, Md.

16. Informant Blanchard Martin

Address Union Bridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 12-1947 (month) (day) (year)

Cemetery or crematory Pipe Creek Cemetery

Location Uniontown, Md.

18. Funeral director H. Bankard Son

Address Westminster, Md.

19. Dec. 11, 1947 (Date rec'd by registrar) Ethel M Melvin Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9th 1947, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...

and that I last saw him alive on ..... 19...

Immediate cause of death	DURATION
Multiple fractures of skull, jaw, arms & legs, internal injuries	
Due to Auto accident	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12-9-47

Where did injury occur? New Taneytown (City or town) Carroll (County) Md. (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Auto accident Injured at work? No

23. SIGNATURE J. Billingslea M.D. acting deputy med. Exam. M. D. or other

Address Westminster, Md. Date signed 12.10.47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct ... is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11684

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Mons., 15 Days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
How long in hospital or institution? Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County
City or town Baltimore-2- (If outside city or town limits, write RURAL and give nearest town)
Street No. 21 Central Ave. (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: CATHERINE MOORE
3.(b) Social Security Number: 220- 24-4011

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) December 20, 1926

8. AGE: Years	Months	Days	If less than one day
20	11	15	... hrs. ... min.

9. Birthplace Charlotte County, Virginia (Town, county, and state)
10. Usual occupation Domestic
11. Industry or business
FATHER 12. Name Ira Moore
13. Birthplace N. Carolina
MOTHER 14. Maiden name Mary Elizabeth Jackson
15. Birthplace Virginia
16. Informant Deceased
Address
17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec 9/1947 (month) (day) (year)
Cemetery or crematory Mt Calvary
Location
18. Funeral director A A Halstead
Address 918 Druid Hill ave.
19. Dec. 5, 1947 (Date rec'd by registrar) Albert R Swearingham Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5, 1947, at 5:30A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20, 1947, to Dec. 5, 1947
and that I last saw her alive on December 5, 1947
Immediate cause of death: Pulmonary Tuberculosis — DURATION: Aug. 1st 1947
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Md. Date signed 12-5-47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940 11085

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 9 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State: Maryland County: Carroll

City or town: Manchester (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John I. Myerly

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Roxanna Baker Myerly (Deceased)

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 26, 1862

8. AGE: Years: 85 Months: 7 Days: 24 If less than one day: hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: William H. Myerly

13. Birthplace: Maryland

MOTHER 14. Maiden name: Sarah Fuhrman

15. Birthplace: Maryland

16. Informant: Charles W. Myerly

Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-23-47 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: St. David York Co. Pa.

18. Funeral director: Jacob Wink's Sons

Address: Manchester, Md.

19. Dec 21 1947 Mrs. W. R. Donner (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 20 1947, at 2:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1945 to Dec. 20 1947 and that I last saw h[illegible] alive on Dec. 20 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	4 days
Due to: Coronary Artery Disease	8 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. C. Porterfield M. D. or other

Address: Hampstead, Md. Date signed: 12-21-47

W

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V8 A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11086

830

Reg. Dist. No. 79

1. PLACE OF DEATH:

County Carroll

City or town Keymar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 minutes

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George W. Newcomer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Laura Shank Newcomer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 7, 1880

8. AGE: Years	Months	Days	If less than one day
67	1	2	..... hrs. ..... min.

9. Birthplace: Md

(Town, county, and state)

10. Usual occupation: Employee Western Maryland Dairy

11. Industry or business

FATHER — 12. Name: Bendigo Newcomer

13. Birthplace: Md

MOTHER — 14. Maiden name: Margaret Bloom

15. Birthplace: Md

16. Informant: Laura Shank Newcomer

Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 12 1947 (month) (day) (year)

Cemetery or crematory: Reformed

Location: Taneytown, Md.

18. Funeral director: C. O. FUSS & SON

Address: Taneytown, Md.

Dec. 11 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1947 at 3.30 P M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Dec 9 1947, to Dec 9 1947

and that I last saw h.. alive on Dec 9 1947

Immediate cause of death: Cerebral Hemorrhage

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. H. Musser M.D. M. D. or coroner

Address Taneytown, Md. Date signed Dec 10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11087

108

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH: County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nina May Parks
3.(b) Social Security Number None

4. Sex female
5. Color or race white
6.(a) Single, married, widowed, or divorced single
6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 10 - 1896
8. AGE: Years 51 Months 5 Days 16 If less than one day hrs. min.
9. Birthplace Baltimore County, Md (Town, county, and state)
10. Usual occupation None
11. Industry or business (Invalid)
FATHER 12. Name Howard C. Parks
13. Birthplace Maryland
MOTHER 14. Maiden name May Gill
15. Birthplace Maryland
16. Informant H C Parks
Address New Windsor, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 29 1947 (month) (day) (year)
Cemetery or crematory Jessups Church Cemetery
Location Cockeysville R.D. Md
18. Funeral director D. D. Hitzler & Sons
Address Union Bridge & New Windsor, Md
19 Dec 29 1947 (Date rec'd by registrar) Emma D Bundick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1947, at 1 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9 1947, to December 26 1947
and that I last saw her alive on Dec 24 1947

Immediate cause of death Pneumonia Lobar — DURATION 2 wks.
Due to
Due to
Other conditions Idiocy
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other
Address Westminster, Md Date signed 12/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1312

11088

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 23 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Mt. Savage (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henry PAUL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE:	Years	Months	Days	If less than one day
	67			..... hrs. ..... min.

9. Birthplace Somerset County (Town, county, and state)

10. Usual occupation - - -

11. Industry or business - - -

FATHER 12. Name Chris PAUL

13. Birthplace Germany

MOTHER 14. Maiden name Magdelina

15. Birthplace Somerset County, Md.

16. Informant Records of Springfield State Hospital

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 9 47 (month) (day) (year)

Cemetery or crematory

Location Springfield Hospital cemetery

18. Funeral director C. H. Green

Address Sykesville, Md.

19. Dec. 9 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1947 at 11:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7 1947 to December 5 1947 and that I last saw him alive on December 5 1947

	DURATION
Immediate cause of death Bronchopneumonia	Nov. 24
Due to	
Due to	
Due to (Chronic ulcers of legs	15 yrs
Other conditions General arteriosclerosis	unknown
Senile psychosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. (Nephroscler.

Autopsy results Bronchopneumonia, Arteriosclerosis,

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Martin Gross, M.D.

Martin Gross, M.D. M. D. or other

Address Springfield State Hosp. Date signed 12/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11089

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 13 Days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 410 Bonneville Ave.
(If rurol, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

Howard Linwood Quinn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 20, 1914

8. AGE: Years	Months	Days	If less than one day
33	9	29	hrs. min.

9. Birthplace: Pocomoke City, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Howard Henry Quinn
13. Birthplace: Pocomoke City, Md.

MOTHER
14. Maiden name: Hattie Bonneville
15. Birthplace: Stockton, Md.

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-22-47 (month) (day) (year)

Cemetery or crematory: Pocomoke

Location: Pocomoke City Md

18. Funeral director: Henry H Watson

Address: Pocomoke City Md

19. Dec. 19 19 47 (Date rec'd by registrar) Albert A. Swarmbaugh Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19 19 47 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6 19 47 to Dec. 19 19 47 and that I last saw him alive on December 19 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 15th 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Swan M.D. M. D. or other

Address: Henryton, Maryland Date signed: 12/19/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1310 11090 Reg. Dist. No. 16

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57 yrs
Hospital, institution, or street address where death occurred:
3 0 yrs
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 278. Church
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Margaret E. Rickle

3.(b) Social Security Number 213-09-5434

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife none
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18 - 1890

8. AGE: Years 57 | Months 11 | Days 5 | If less than one day ... hrs. ... min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John E. Rickle
13. Birthplace Westminster, Md.

MOTHER
14. Maiden name Mary Harman
15. Birthplace Westminster, Md.

16. Informant Mrs Pauline Rickle
Address 27 S. Church St. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 27-1947 (month) (day) (year)
Cemetery or crematory St. John Cemetery
Location Westminster Md.

18. Funeral director Harbaugh Son
Address Westminster, Md.

19. 12/26 1947 (Date rec'd by registrar) H. Caylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1947, at 10:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1947, to December 23 1947 and that I last saw h.er alive on December 23 1947

	DURATION
Immediate cause of death Pneumonia	
Hypostatic	4 days
Due to Hypertension & cardio	1940
Renal disease &	
Due to Cerebral Hemorrhage	1946
& Hemiplegia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Glenn Fletcher M. D. or other
Address Westminster Md. Date signed 12/24/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11091

30C

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Carrol

City or town: Rural, Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs, 9 mo.

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs, 9 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: ~~Baltimore~~

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1716 s. Charles St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: RIEDEL, Edward C.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Martha Riedel

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): January 9, 1884

8. AGE:

Years	Months	Days	If less than one day
63	11	3	...hrs. ...min.

9. Birthplace: Baltimore City, Md. (Town, county, and state)

10. Usual occupation: ~~huckster~~ produce dealer

11. Industry or business:

FATHER 12. Name: Edward C. Riedel

13. Birthplace: Baltimore City, Md.

MOTHER 14. Maiden name: Lillie Liesner

15. Birthplace: Baltimore City, Md.

16. Informant: Records of Springfield State Hosp. Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/16/47 (month) (day) (year)

Cemetery or crematory: Savage, Md.

Location:

18. Funeral director: WM. J. TICKNER & SONS Address: Balto., Md.

19. Dec 16, 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12, 1947, at 9.55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1947, to December 12, 1947 and that I last saw h...im...alive on December 12, 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	7 hrs.
Due to: Syphilis	?
Due to:	
Other conditions: Psychosis with Syphilis of C.N.S., meningo vascular type. Asthma.	2½yrs 1-2yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.:

Autopsy results: Myocardial hypertrophy, volvulus

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work?

Martin Gross, M.D.

23. SIGNATURE: Martin Gross, M.D. M. D. or other

Address: Sykesville, Md. Date signed 12-13-47

11693

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 Days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1723 Mc Kean Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Helen Lee Robertson

3.(b) Social Security Number: 218-18-6450

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Married

6.(b) Name of husband or wife: James Robertson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 12, 1916

8. AGE: Years	Months	Days	If less than one day
31	2	23	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Charles Blackwell
13. Birthplace: New Jersey

MOTHER
14. Maiden name: Daisy Marshall
15. Birthplace: Virginia

16. Informant: Sister: Mrs. Ruth Lovett

Address: 1432 Belvedere St. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/9/47 (month) (day) (year)

Cemetery or crematory: Mt Auburn

Location: Mt Wilson

18. Funeral director: Wm Samuel S Hemsley

Address: 518 W. Biddle St.

19. Dec. 5 1947 (Date rec'd by registrar) Albert R. Brumbley Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 1947 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 1947 to Dec. 5 1947 and that I last saw her alive on December 5 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2/23/44
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben H Fraun M.D. M. D. or other

Address: Henryton, Md. Date signed 12/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13E

1109279

Reg. Dist. No. 79

W

1. PLACE OF DEATH:
County Carroll
City or town Detour- Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Carroll
City or town Mr Detour
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Mrs. Amanda E. Roop

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Charles W. Roop
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 4, 1907

8. AGE:

Years	Months	Days	If less than one day
40	7	4	..... hrs. ..... min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name William D. Shildt
13. Birthplace Md
MOTHER 14. Maiden name Maggie Few
15. Birthplace Md
16. Informant Charles W. Roop
Address Detour, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/11/47 (month) (day) (year)
Cemetery or crematory Keysville
Location Keysville, Md.
18. Funeral director C. O. FUSS & SON
Address Taneytown, Md.
19 Dec 11 1947 Nancy M. K. Pennell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1947 at 6:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9 1947 to Dec. 9 1947 and that I last saw her alive on Dec. 8 1947

	DURATION
Immediate cause of death	
Pulmonary Tuberculosis	3 yrs
Due to Pulmonary	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. H. Legg M. D. or other
Address Union Bridge Date signed 12-10-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46a 11094

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll Co.

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 4 Months

Hospital, institution, or street address where death occurred: 27 E. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 27 E. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Mary Jane Shipley

3. (b) Social Security Number none

4. Sex f

5. Color or race w

6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Grove J. Shipley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1866

8. AGE: Years 81 Months 0 Days 8 If less than one day ..... hrs. ..... min.

9. Birthplace Frederick Co. Maryland (town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Rufus Musbaum

13. Birthplace Maryland

MOTHER 14. Maiden name Rebecca Shipley

15. Birthplace Carroll Co. Md.

16. Informant Mrs. Charles Young

Address Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 23/47 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster, Md.

18. Funeral director J. E. Myers Jr.

Address Westminster Md.

19. 12/22 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20th 1947, at 12.05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1947, to Dec 20 1947

and that I last saw h[illegible] alive on Dec 19 1947

Immediate cause of death Carcinoma of Oesophagus — DURATION 1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas R Fouty M.D. (M. D. or other)

Address Westminster Md. Date signed 12-22-47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74 — 11095

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 14 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Mt. Lake Park, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Zacherias Spiker

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.): June 14th 1911 — 6.(c) If alive, give age: years

8. AGE: Years	Months	Days	If less than one day
36	6	0	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: Charles B. Spiker

13. Birthplace: Unknown

MOTHER — 14. Maiden name: ? Unknown

15. Birthplace: Unknown

16. Informant: Records of Springfield State Hosp.

Address: Sykesville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec 23 1947 (month) (day) (year)

Cemetery or crematory: Springfield State Hospital Cem.

Location: Sykesville Maryland

18. Funeral director: C. Harry Weis

Address: Sykesville Maryland

19. Dec 23 1947 (Date rec'd by registrar) C. Harry Weis, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 1947, at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1947, to December 14 1947

and that I last saw him alive on December 14 1947

Immediate cause of death	DURATION
Organic brain disease, nature and cause unknown (hemorrhage ?, encephalitis ?)	more than 3 months.
Due to:	
Due to:	
Other conditions: Mental deficiency,	life-long
decubitus (Include pregnancy within 3 months of death)	1 month

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Martin Gross, M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 12/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d & 11096

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yr 2 mo - 24 da

Hospital, institution, or street address (if not in hospital or institution): Springfield State Hosp.

How long in hospital or institution? 15 yr - 2 mo - 24 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: N

3. (a) FULL NAME: Barbara Anna Stonesifer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1878 - 9 - 1

8. AGE: Years: 69 Months: 3 Days: 27 If less than one day: hrs. min.

8. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Factory Worker

11. Industry or business: Button

FATHER — 12. Name: William Henry Stonesifer

FATHER — 13. Birthplace: Pa

MOTHER — 14. Maiden name: Caroline Wall

MOTHER — 15. Birthplace: Pa

16. Informant: Mrs Margaret Phillips

Address: Sykesville Md

17. (Burial, ~~cremation, or removal~~. Which?) Burial Date thereof: 12-31-47 (month) (day) (year)

Cemetery ~~or crematory~~: Loudon Park

Location: Baltimore, Md

18. Funeral director: C.M. Waltz

Address: Winfield, Md

19. (Date rec'd by registrar) Dec 31 1947 C. Harry Wm. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 28 1947 at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4th 1937 to Dec 28 1947 and that I last saw h[illegible] alive on Dec 28 1947

Immediate cause of death	DURATION
Chr. Myocarditis	10 yrs
Due to:	
Due to: Hypertension	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. J. Gaston M.D. M. D. or coroner

Address: Sykesville Md Date signed: 12/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462 / 11097

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, Institution, or street address where death occurred:
R.D. # 3
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. # 3
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edna Earle Stumble

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife George W. Stumble
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 18 – 1871

8. AGE: Years	Months	Days	If less than one day
76	2	14	..... hrs. ..... min.

8. Birthplace Lovettsville, Va.
(Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Samuel Wright
13. Birthplace Va.
MOTHER 14. Maiden name Margaret Fawley
15. Birthplace Va.
16. Informant Mrs. Clara Stumble
Address Westminster R.D. 3. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 4, 1947 (month) (day) (year)
Cemetery or crematory Bachmans Cemetery
Location Westminster 3. Md.
18. Funeral director H. Bankard & Son
Address Westminster, Md.
19. 12/2 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1947 at 11 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8 1947 to Dec. 2, 1947
and that I last saw h.er alive on December 2 1947

Immediate cause of death	DURATION
Cancer Intestine	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Reece Lord Sens M. D. or other
Address Westminster md Date signed 12/2/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

11098

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Patapsco

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Patapsco

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Charles Emory Taylor

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Elizabeth Taylor

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): March 20, 1876

8. AGE:

Years	Months	Days	If less than one day
71	8	19	...hrs. ...min.

9. Birthplace: Patapsco, Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: William H. Taylor

13. Birthplace: Maryland

MOTHER

14. Maiden name: Frances A. Taylor

15. Birthplace: Maryland

16. Informant: Mrs. Chas. E. Taylor

Address: Patapsco, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12/13/47 (month) (day) (year)

Cemetery or crematory: Carrollton Church of God

Location: Carrollton, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 12/9/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9, 1947, at 9½p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11th 1947, to Dec 9th 1947

and that I last saw him alive on Dec. 8, — 1947.

Immediate cause of death	DURATION
Acute cardiac dilatation	6 hrs
Due to Chronic Myocarditis	2 yrs
Due to Chronic Interstitial Nephritis	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: Chas R Taylor MD (M. D. or other)

Address: Westminster Md. Date signed 12-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Evidence for change of age and birthdate shown on:

FILM No. G 114 DEC 18 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11699

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos. 22 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Bramch, Henryton

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1820 Pennsylvania Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Thomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) ~~May 4, 1892~~ June 4, 1882

8. AGE: Years	Months	Days	If less than one day
~~85~~ 65	~~7~~ 6	~~9~~ 4	hrs. min.

9. Birthplace: Charles Co. Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER

12. Name: Samuel Thomas

13. Birthplace: Charles Co. Md.

MOTHER

14. Maiden name: Julia Green

15. Birthplace: Charles Co. Md.

16. Informant: Sister: Bertha Jackson

Address: 1820 Pennsylvania Ave. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 19 1947 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location:

18. Funeral director: A A Adolphus Halstead

Address: [illegible]

19. Dec. 13, 19 47 (Date rec'd by registrar) Albert R. [illegible] Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13, 1947 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21 1947 to Dec. 13 1947 and that I last saw him alive on December 13 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 1947

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. (M. D. or other)

Address: Henryton, Md. Date signed: 12/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a 11180

Reg. Dist. No. 75

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Carroll

City or town: near Melrose, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: near Melrose, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mrs Lettilda Tracy

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mr. Charles H. Tracey

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Oct 8,1867. 80yrs 2mo 21dys

8. AGE: Years	Months	Days	If less than one day
80	2	21	... hrs. ... min.

9. Birthplace: York County
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Michael Trone
13. Birthplace: York County

MOTHER
14. Maiden name: Mrs Kline
15. Birthplace: York County

16. Informant: Charles H. Tracey
Address: Manchester, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-1- 48 (month) (day) (year)

Cemetery or crematory: Lazraus Lutheran Cemetry

Location: Lineboro, Md.

19. Funeral director: David R. Martin
Address: Manchester, Md.

19. Dec. 30 1947 (Date rec'd by registrar) Mrs. W. J. S. Denner, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29 1947 at 12:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 29 1929, to Dec. 29 1947
and that I last saw her alive on Dec. 24 1947

		DURATION
Immediate cause of death	Coronary Insufficiency c Angina	6 mo.
Due to	Coronary Arterio-sclerosis	2-3 yrs.
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Maurice C. Porterfield M. D. or other

Address: Hampstead, Md. Date signed 12-31-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11101

93a

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(Or newborn infant, give residence of mother)
State: Maryland County: Carroll
City or town: Manchester Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lana V. Trump.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles Edward Trump.
6.(c) If alive, give age: 75 years
7. Birth date of deceased (mo., day, yr.): February 6, 1875

8. AGE: Years	Months	Days	If less than one day
72	10	6	hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: Jacob Farow
13. Birthplace: Maryland
MOTHER 14. Maiden name: Elizabeth Fring.
15. Birthplace: Maryland
16. Informant: Charles Edward Trump.
Address: Manchester, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof 12/16/47 (month) (day) (year)
Cemetery or crematory: Bunker Hill Cemetery
Location: Waynesboro Pa
18. Funeral director: Walter Y. Gore
Address: 278 Church St. Waynesboro, Pa
19. Dec 12 1947 (Date rec'd by registrar) Mrs. W. P. S. Demuth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 1947 at 4 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9 1947, to December 12 1947
and that I last saw h.. alive on December 12 1947
Immediate cause of death: Coronary Occlusion — DURATION: 10 hrs
Due to: Chronic Myocarditis. — ?
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jos. E. Bush MD M. D. or other
Address: Waynesboro Md Date signed 12-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11102

830

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County Carroll
City or town Sykesville,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 27 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore County
City or town Phoenix
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME a HOWARD ERNEST WILLIAMS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife Mary E. Gibson
6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) ~~1/30/1879~~ Apr. 30, 1881

8. AGE: Years	Months	Days	If less than one day
66	7	10	hrs. min.

9. Birthplace Syracuse, New York
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business

FATHER
12. Name Judson Williams
13. Birthplace New York

MOTHER
14. Maiden name Nannie Hopkins
15. Birthplace New York

16. Informant Record, Springfield State Hospital
Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 13 1947 (month) (day) (year)
Cemetery or crematory Jennings
Location Sparks, Maryland

19. Funeral director Landon M. Brooks
Address Sparks, Md.

19. Dec 11 19 47 (Date rec'd by registrar) Harry Keer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 19 47, at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-13 19 47 to 12/10 19 47 and that I last saw him alive on 12/10 19 48

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 minutes
Due to: Cerebral Arteriosclerosis	
Due to:	
Other conditions: Psychosis - Cerebral Arteriosclerosis	7 years

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Arnold H. Eichert, M.D. M. D. or other
Address S.S.Hosp., Sykesville, Md. Date signed 12-11-47

Evidence for change of age
shown on Film G114
1/6/48 dm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

D 11103

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 mos. 17 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Branch Colored Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 120 W 21 Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Stanley Augustus Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 9, ~~1906~~ 1909

8. AGE: Years	Months	Days	If less than one day
~~41~~ 38	7	14	hrs. min.

9. Birthplace: West Indies (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec-27-47 (month) (day) (year)
Cemetery or crematory: Mt Cabary
Location: Brooklyn N. J.
18. Funeral director: Wm Brooks Ruggold
Address 1463 N Carey St.
19. Dec 23 19 47 (Date rec'd by registrar) Albert R. Swanborn Registrar Local Deputy

MEDICAL CERTIFICATION P.

20. DATE OF DEATH: December 23 19 47 at 6:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6 19 47, to Dec. 23 19 47 and that I last saw him alive on December 23 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben F. Ross, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 12/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11104

50

CERTIFICATE OF DEATH

Reg. Diat. No. 70

1. PLACE OF DEATH:
County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Mrs. Cora B. Witherow

3.(b) Social Security Number
none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife J. W. Witherow
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1867

8. AGE: Years	Months	Days	If less than one day
80	8	15	hrs. min.

9. Birthplace Adams County, Pa.
(Town, county, and state)

10. Usual occupation housework

11. Industry or business

FATHER
12. Name Jonathan Allison
13. Birthplace Pa

MOTHER
14. Maiden name Mary Jane Pitzer
15. Birthplace Pa

16. Informant Miss Grace Witherow
Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 20, 1947. (month) (day) (year)
Cemetery or crematory Lutheran
Location Taneytown, Md.

18. Funeral director C. O. FUSS & SON
Address Taneytown, Md.

19 Dec 19, 1947 (Date rec'd by registrar) Ethel M. Melring, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1947, at 2 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March, 1947, to Dec. 17, 1947 and that I last saw her alive on Dec. 17, 1947

Immediate cause of death	DURATION
cardio-renal failure	
Due to Adeno-carcinoma, right breast	
2 vertebral metastases	
Due to Chronic Bronchiectasis	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. A. Bradley Jr. M. D. or other
Address Taneytown, Md. Date signed 12-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 93d

Reg. Dist. No. 11115 76

1. PLACE OF DEATH:
County: Carroll
City or town: Woodensburg Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: Woodensburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sarah Elizabeth Wooden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Alexander Wooden
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 7th 1853

8. AGE: Years	Months	Days	If less than one day
94	2	1	..... hrs. ..... min.

9. Birthplace: Woodensburg Md. (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business: Self

FATHER
12. Name: George Jacob Wuster
13. Birthplace: Woodensburg Md.

MOTHER
14. Maiden name: Sarah Elizabeth Musselman
15. Birthplace: Woodensburg Md.

16. Informant: Ernest E. Wooden
Address: Woodensburg Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 11/10/47 (month) (day) (year)
Cemetery or crematory: Mt. Gilead
Location: Carroll Co. Md.

18. Funeral director: William Cook Inc.
Address: 1217 St. Paul St

19. Dec 9 1947 (Date rec'd by registrar) J. W. Fridinger Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 8 1947, at 2 30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-32 1918 to 12/8/47 1918 and that I last saw h.r alive on 12-7-47 1918

Immediate cause of death	DURATION
myocarditis	3 yrs.
Chronic decompensation	
Due to: Hypertension.	yrs.
Due to: Arteriosclerosis.	yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: ✓
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ✓ Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ✓
Means of injury ..... Injured at work?

23. SIGNATURE: James A. Saffell M. D. or other
Address: Westminster Md. Date signed 12/8/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING